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ABSTRACT

The psychiatric/behavioral science component of the medical school curriculum at Texas A&M University, which involves a pediatric psychology rotation, is described. The content areas of pediatric psychology includes the basic curriculum areas of child/adolescent psychodiagnostic categories, behavioral/developmental disorders, and knowledge of individual psychopathology. The student must comprehend individual and family dynamic theory, child/adolescent development, and the impact of the environment on the child/adolescent. In terms of process areas of learning, the student develops interviewing skills and the ability to build meaningful rapport with the patient within the context of the doctor-patient relationship. In order to internalize the process of pediatric psychology, the medical student must usually show an attitudinal change departing somewhat from the traditional medical model approach, which differs from the biopsychosocial model. The medical students are exposed to diagnostic controversies between medicine and psychiatry, treatment and management of physical illnesses and disease from a psychiatric perspective, and the impact and importance of the doctor-patient relationship. Students receive clinical exposure to pediatric psychology within both the psychiatry and pediatric clerkships. During assignment to pediatric psychology, students observe clinical diagnostic interviews and may join the psychologist in therapy sessions. Students also are exposed to a multidisciplinary team that evaluates children with behavioral, emotional, learning, and developmental disorders. A bibliography is appended. (SW)

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TEACHING PEDIATRIC PSYCHOLOGY CONCEPTS TO MEDICAL STUDENTS

Even for those future physicians who do not choose psychiatry or pediatrics for specialties, the knowledge and skills learned in pediatric psychology during medical school can be valuable in helping understand mental health issues as they impinge upon physical medicine. The teaching of behavioral science concepts has often been met with resistance in many medical school programs (Turnbull, 1978). The relevance of the social sciences to medical education has been questioned since it frequently does not reflect a medical model approach (Begun & Rieker, 1980). In recent years, the number of medical students applying to psychiatry residency programs has drastically decreased. Medical students perceive psychiatry as being out of the mainstream of medicine, as being infrequently effective for patients and as conferring low status on its practitioners. In addition, students who express an interest in psychiatry are often stigmatized and pressure is put on them to change their choice of career (Nielsen, 1979). Medical education appears to have done a poor job in promoting psychiatry and behavioral sciences.

Teaching pediatric psychology concepts to medical students offers an excellent opportunity to help students discover a pragmatic approach to interfacing social/behavioral science and medicine. Children offer a good opportunity for students to learn about the impact of developmental stages of growth, family dynamics, and the relationship between physical illness and emotions by practical, common sense examples. In a recent

survey of psychiatrists, psychologists, and non-psychiatric physicians, child development and child/adolescent behavior disorders were perceived as moderately to very important for inclusion within the medical school psychiatry curriculum, but these topics were not regarded as being crucial. In addition, psychiatrists and psychologists often differ in the relative importance they place on other aspects of a pediatric psychiatry/ psychology curriculum (Johnson & Snible, 1975).

The psychiatric/behavioral science component was integrated within the medical school curriculum during the early stages of conception in the College of Medicine of Texas A&M University. In addition, all the behavioral science faculty within the Department of Psychiatry and Behavioral Science have had experience in the health care field, which has enhanced positive student acceptance of the curriculum (Hurster, 1980). Psychologists offer some advantages over other mental health professionals when teaching psychological principles. They often have specialized training which can be exceptionally valuable in the teaching of child/ adolescent development. Pediatric psychologists are knowledgeable in the use of psychometric instruments for assessing psychological functioning, in the research literature which provides the underpinning for current clinical practice, and in a knowledge of a wide variety of psychologic approaches for treating children, adolescents, and families (Wallace & Rothstein, 1977). In addition,research in psychology has provided a plethora of practical information on child development which can be valuable aiding the student physician in understanding human psychological growth.

Many authors have enumerated some of the purposes and goals of a medical school experience in pediatric psychiatry. (Cove, Kaplan, Baxter, Berman, Rieger, Denham & Lourie, 1976; Fine, 1979; Krell, Miles & Maurice, 1974; Lewis, 1973) Although many of these topics/curriculum areas are similar to the goals and purposes of a pediatric psychology experience, a pediatric psychology rotation can offer a unique contribution to a medical school curriculum. Almost every subject taught in the medical school and every field of medical practice in some way can be related to the psychological development of the child (Lewis, 1973). Pediatric psychology can be viewed as an integrating matrix for all medicine; the pediatric psychologist can become an important resource person and role model in support of the concept of a multidisciplinary approach to children's health care. The medical student on a pediatric psychology rotation must be initially exposed to the theories of child, adolescent, and family psychology. Through his experience the student will be able to conceptualize the human life cycle from a developmental point of view. In addition, the student will be able to identify specific developmental stresses which effect child and adolescent functioning. The student should also be able to develop an appreciation of the effect of cognitive maturation upon a child's understanding of his environment. A thorough theoretical background in pediatric psychology will help the medical student to integrate concepts involving constitutional influences with personality formation and mental development. An understanding of the impact of socioeconomic factors and family dynamics can aid the student in understanding psychological functioning within a medical setting. The rotation must stress a theoretical understanding of illness and hospitali-

zation and its effect on emotional/personality functioning. The medical student must also be exposed to the psychological and emotional ramifications of the medical treatment process (Fine, 1979). Finally, the student should have some basic theoretical understanding of psychopathology in order to better conceptualize individual and family psychodynamics of the defenses used by children, adolescents, and families as well as predicting behavior in certain circumstances.

The medical student participating in pediatric psychology will develop knowledge and awareness of common child and adolescent problems and psychopathology which effects behavior, development and adaptation. In addition to identification of these problem areas, the student will be able to formulate a rudimentary intervention approach to the problem. The student will also be able to discriminate between normal and abnormal psychological functioning. With this knowledge and understanding, the student physician can facilitate optimal psychological adjustment and adaptation for his/her patients.

In a more practical vein, the medical student must develop interaction skills with children, adolescents, and families. The medical student should learn how to interview children and adolescents. Included in this knowledge would be an appreciation of the meaning of symbolic play for the child. The medical student must develop an understanding of and a sensitivity to some of the special problems of childhood and youth as well as being able to emphatically respond to these problems. The medical student should learn to share psychologically relevant findings with the patient or family

without escalating defensiveness or resistance to that interpretation. Finally, it is important that the medical student develop self-awareness as to his/her own psychological and emotional reactions within the doctor-patient interaction. The medical student must be aided in developing self-awareness as to how constructive or destructive his/her interaction can be for the child, teenager, or family.

The medical students' acceptance or rejection of the curriculum has been shown to be critically influenced by the students' responses to the material on an affective level (Cove, et al, 1976). The Texas A&M University College of Medicine is not significantly different from the majority of medical schools in that although physical medicine is acknowledged to be influenced by psychological/psychiatric factors, the medical students themselves often show resistance to accepting and utilizing the biopsychosocial model. Each medical student is exposed to as much psychologically-oriented material as his individual personality can tolerate. Therefore, each component of the pediatric psychology curriculum must be structured in order to provide both technical information and effective monitoring of the students' affective experience. In this way, the student will learn the content of pediatric psychology, but will not be overwhelmed emotionally by the experience. This attention to the affective experience of the student is immensely important if the learning process is to be facilitated without resistance.

Numerous pediatric psychiatry medical school training programs have been discussed elsewhere (Cove, et al, 1976; Forgotson & Sweeney, 1977; Lewis, 1973; Krell & Maurice, 1974; Schuman & Gross, 1978). The program in the Department of Psychiatry and Behavioral Science at the Texas A&M University College of Medicine is unique in terms of its innovative approach to medical education. Although pediatric psychology is only a small portion of the psychiatry curriculum, an attempt is made to provide an intensive, meaningful experience. The teaching is divided between two campuses; the freshman and sophomore medical students are taught primarily using a didactic format at the College Station campus while the junior and senior students participate in clinically-oriented clerkships at the Temple campus some ninety miles away. Faculty consists of staff from both Scott and White Clinic and the Teague Veterans Center, the two teaching hospitals of the medical school. Unlike many psychiatry and behavioral science faculties (Wallace & Rothstein, 1977), psychiatrists, psychologists, and other mental health professionals work together without intra-professional animosity.

Within the didactic component the freshmen medical students are exposed to lectures on human development which emphasize the developmental theories of Freud, Erikson, and Piaget as well as normal psychological processes within a biopsychosocial framework. In addition, aspects of the human life cycle are discussed which include defense mechanisms and characteristic coping patterns. The medical students are also exposed to diagnostic controversies between medicine and psychiatry, treatment and management of physical illnesses and disease from a psychiatric perspective, and the

impact and importance of the doctor-patient relationship. This first year course work is designed to provide the students with the language and vocabulary so they can develop a conceptual/theoretical understanding of psychiatric, psychological and developmental functioning. The sophomore didactic component in psychiatry is presented in nine day-long workshops where various topics of psychiatric practice is discussed. A small group, discussion format (Brownstein, Singer, Dornbush & Freeman, 1979) is used extensively to stimulate student interest. The sophomore workshops which are most relevant to the teaching of pediatric psychology are concerned with biopsychosocial medicine, family and group psychodynamics, psychotherapy, and child and adolescent disorders. Concurrent with the sophomore psychiatry curriculum, the Department of Pediatrics presents a series of lectures on the human life cycle (Hartings & Counte, 1977) describing common child and adolescent medical, developmental, psychological, and behavioral disorders. As the medical students begin the junior year and prior to beginning a two-month clinically-oriented clerkship in psychiatry, they participate in a week-long lecture series on psychiatry. In addition, in connection with their clinical work, the students are often asked to read various articles of relevance to patients that have been seen.

Although the medical students do not have a clinical experience until the junior year, they receive clinical exposure to pediatric psychology within both the psychiatry and pediatric clerkships. Within the psychiatry clerkship, students who are rotating with the Scott and White consultation/liaison service are assigned to pediatric psychology as time permits. The student is asked to observe clinical diagnostic interviews of children,

adolescents, and families with a child psychologist. The student's activity level within the interviews increases with his/her experience. In the same way, during the pediatric clerkship, a medical student is routinely assigned two hours every week to pediatric psychology for a similar clinical experience. If the medical student becomes extremely interested in a diagnostic case which then becomes a psychotherapy case, the medical student can join the psychologist in therapy sessions during the two-month pediatric lerkship. Finally, the medical student is exposed to the Scott and White Child Development Team, a multidisciplinary team consisting of a social worker, pediatric psychologist, pediatric geneticist, occupational therapist, and speech pathologist who routinely evaluate children with behavioral, emotional, learning, and developmental disorders. This experience is similar to a program described at the Children's Hospital National Medical Center in Washington, D.C. (Cove, et al, 1976) where the advantages of a multidisciplinary approach are revealed.

Medical students appear to be most interested in direct patient contact (Brownstein, et al, 1979; Werkman, Lundau & Wakefield, 1973). During the pediatric psychology experience, an attempt is made to have the student develop clinical skills by giving them progressive responsibility as they become more comfortable and skilled in interacting with children and adolescents. The student is also given assigned readings relevant to the clinical cases he has been exposed to. This integration of clinical and academic learning makes the pediatric psychology experience especially worthwhile to the student (Brownstein et al, 1979).

When teaching pediatric psychology to medical students, both content and process areas of learning must be addressed. Within the content area of pediatric psychology would be the basic curriculum on such things as child/adolescent psychodiagnostic categories, behavioral/developmental disorders, and knowledge of individual psychopathology. In addition, the student must comprehend individual and family dynamic theory, child/adolescent development, and the impact of the environment on the child/adolescent. This knowledge of theory and facts comprising the content of pediatric psychology would be sterile without an appreciation for the process of applying these pediatric psychology concepts. Within this process area, the medical student should be able to develop an ability to think "psychologically". In order to internalize the process of pediatric psychology, the medical student must usually show an attitudinal change. The medical student must depart somewhat from the traditional medical model approach to the understanding of the patient and be ready to give up the emotional insulation that goes along with the highly technical practice of medicine. Within the process of pediatric psychology, the student develops interviewing skills and the ability to build meaningful rapport with the patient within the context of the doctor-patient relationship. Although knowledge of the content of pediatric psychology will allow the student to conceptualize facts, categories, and theories, the exposure to the art of the application of these concepts, that is, the process of pediatric psychology, will aid the student physician in providing total care to his patients. Even the most elementary exposure to pediatric psychology process is felt to develop greater sensitivity to the human condition, which is a necessary part of any medical practice.

Although it is not anticipated that the medical student will fully develop all the clinical skills necessary for superior medical practice, the student's exposure to a competent child-oriented clinician in conjunction with the didactic material has been valuable in sensitizing the student to the unique skills which working with children and adolescents require. Medical students, after exposure to pediatric psychology, are able to more competently identify the underlying dynamics within the family, "listen" to verbal and nonverbal communication more effectively, and be able to interview children and adolescents with more emotional depth. This sensitivity developed by the medical students to the underlying psychological processes is the most valuable contribution that the pediatric psychology experience provides and helps temper and organize future educational experiences for the student.

For the medical student who has been overexposed to an inflexible medical model approach and unappreciative of the biopsychocosial model, the involvement with pediatric psychology can open up new insights into the impact of psychosocial issues in physical medicine. Students often have more appreciation for the power of the emotionally therapeutic relationship which develops between doctor and patient tnat is crucial in any clinical practice of medicine. Within a pediatric setting, the psychosocial issues are more apparent. In addition, medical students can feel less emotionally threatened working with children than working with a peer-aged patient population. A previous study has shown that an

experiential, affectively-oriented pediatric psychiatry/psychology training has helped medical students to have significant increases in their interest in psychiatry, increased empathy for patients, and a significant decrease in anxiety in relating to patients (Werkman, et al, 1973). By becoming more aware of psychosocial issues in a pediatric psychology experience, the future physician will be more likely to concern himself with the prevention of emotionally damaging experiences which negatively affect medical treatment and which have been shown to later contribute to adult psychopathology.

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